

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

093952 02
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
KENT		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY Kent	
Rural - Chestertown	1 month	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
EDGAR	URIAN	Beverage	Sept	27	1956		

5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
Male	W	Don't know	WIDOWED	Jan. 13, 1916	40 yrs.	Months	Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Farm	Marlinton, W. Va.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wm. F. Skinner Beverage	Cora H. Sharpe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
J.W. W. II	297-09-7833	Employment Agency	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 825 X Freckled skull	none
Conditions, If any, which gave rise to immediate cause (b)	
(c)	
DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	19. WAS AUTOPSY PERFORMED?
	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Hour am. p.m. 9/27 1956	Passenger in front seat of auto in collision -

20c. TIME OF INJURY Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour am. p.m. 9/27 1956	White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	County road near Chestertown	Kent	Md	

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL SIGNATURE	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
ROBERT W. FARR	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	9/27/56
EXAMINER'S NAME (Type)	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Sept. 1, 1956	Loudonville Cem.	Loudonville, Ohio

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
J. Wells Wells	Chestertown, Md.	Sept. 29-56	Clarice Barnes

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
 5M 9/55

BUREAU V. 8

OCT 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09396

Reg. Dist. No. 202

CERTIFICATE OF DEATH

9402

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Kent				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 13 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital				d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? / YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First John	Middle W.	Last Colby	4. DATE OF DEATH Sept. 30, 1956	Month	Day	Year
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH Aug. 14, 1882	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Realtor		11. BIRTHPLACE (State or foreign country) New York State			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John F. Colby				14. MOTHER'S MAIDEN NAME Mary A. Brotherton				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. 213-22-7048		17. INFORMANT Edith B. Colby		Address Chestertown, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory collapse INTERVAL BETWEEN 442X DUE TO ONSET AND DEATH 48 hrs.								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Cardiovascular - renal disease 12 mos.								
DUE TO (c) Atherosclerosis, generalized 3 years.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1953, 1953, to 9-30, 1953, that I last saw the deceased alive on 9-30, 1953, and that death occurred at 6 P.M., from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>A. C. Dick</i> ADDRESS (Street, city or town, state) Chester town, Md. DATE SIGNED 10/1/56								
PHYSICIAN'S NAME (Type) A. C. Dick		Chestertown, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 3, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Kensico Cemetery		22d. LOCATION (City, town, or county) (State) Westchester Co. New York		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		ADDRESS Chestertown, Md. 24a. REC'D BY REGISTRAR DATE Oct. 2-1956 Clarinda Barnes						
		24b. REGISTRAR'S SIGNATURE						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH - SANITATION - STATE OF NEW YORK

CERTIFICATE OF DEATH

REG. NO. 1000

BUREAU Y. S.

OCT 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 69397

Item 20 Film G204 10-5-56 ams 9413 CERTIFICATE OF DEATH Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 1b		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Kent		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 107 N. Queen St.							
3. NAME OF DECEASED (Type or print) CATHY CULVER, COLLINS		First	Middle	Last	4. DATE OF DEATH Sept. 21 1956	Month	Day	Year			
S. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 1 1955	9. AGE (In years last birthday) 1 yrs.	10. IF UNDER 1 YEAR Months 1 yrs.	11. IF UNDER 24 HRS. Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Chestertown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME William H. Collins		14. MOTHER'S MAIDEN NAME Helen Marie Culver									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mr. Wm. H. Collins Chestertown, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Blockage of trachea due to aspiration		DUE TO of vomitus				INTERVAL BETWEEN ONSET AND DEATH 10 min.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ----- (c) -----		DUE TO ----- (c) -----									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Upper respiratory infection						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -----		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Vomited ingested food									
20c. TIME OF INJURY Hour 6:00 p.m.	Month 9	Day 21	Year 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Chestertown	(County) Kent	(State) Md			
21. I certify that I attended the deceased from 9-21 , 19 56 , to 9-27-56 , 19 56 , that I last saw the deceased alive on 9-21-56 , 19 56 , and that death occurred at 6:15 p.m. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Chestertown, Md.					
ACTUAL SIGNATURE A.C. Dick		M.D.				DATE SIGNED					
PHYSICIAN'S NAME (Type) A.C. Dick		Chestertown, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 23/56	22c. NAME OF CEMETERY OR CREMATORIUM St. Paul Cemetery	22d. LOCATION (City, town, or county) Fairlee, Kent Co. Md.	(State)							
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams, Chestertown, Md.		ADDRESS Marvin V. Williams, Chestertown, Md.	24a. REC'D BY REGISTRAR REC'D 30 SEPT 1956	24b. REGISTRAR'S SIGNATURE Clara Barnes							

DEPARTMENT OF HEALTH - BALTIMORE CITY
CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
SEP. 26 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

69398

9498

CERTIFICATE OF DEATH

Reg. Dist. No. 2021

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Kent		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b life		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. # 2				d. STREET ADDRESS R.F.D. # 2						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary E. Cooper		First	Middle	Last	4. DATE OF DEATH Sept. II, 1956	Month	Day	Year			
S. SEX female	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 10, 1884		9. AGE (In years lost birthday) 72 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife and Laborer at Cannery		10b. KIND OF BUSINESS OR INDUSTRY Cannery		11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Wm. Thomas Brown				14. MOTHER'S MAIDEN NAME Sarah Cotton							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-26-8020		17. INFORMANT J. Thomas Cooper		Address Chestertown, Md. R.F.D. # 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute indigestion INTERVAL BETWEEN ONSET AND DEATH											
543X DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic gastritis											
DUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 9/10 , 19 56 , to 9/11 , 19 56 , that I last saw the deceased alive on 9/11/56 , 19 56 , and that death occurred at 5 P.M. from the causes and on the date stated above.											
ADDRESS (Street, city or town, state) ADDRESS DATE SIGNED Sept. 12, 1956											
ACTUAL SIGNATURE E Kester											
PHYSICIAN'S NAME (Type) Eugene Kester Rock Hall, Maryland											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/15/1956		22c. NAME OF CEMETERY OR CREMATORIUM Georgetown Cem.		22d. LOCATION (City, town, or county) Chestertown, Md. R.F.D. 2		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR Sept. 13-1956		24b. REGISTRAR'S SIGNATURE Classie L. Barnes					

CERTIFICATE OF DEATH

BUREAU Y.
RECEIVED
SEP 17 1956

may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9409

CERTIFICATE OF DEATH

69399

Reg. Dist. No. 203

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. LENGTH OF STAY IN 1b 9 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Willis Middle Francis Last Dagenais		4. DATE OF DEATH Sept. 26, 1956 Month 19 Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 8, 1908 9. AGE (In years from last birthday) 48 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt.		10b. KIND OF BUSINESS OR INDUSTRY Concrete Products	11. BIRTHPLACE (State or foreign country) Canada
13. FATHER'S NAME Joseph W. Dagenais		14. MOTHER'S MAIDEN NAME May (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. E13-I2-9443	17. INFORMANT Mrs. Minnie D. Dagenais Address Rock Hall Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Infective Diarrhoea DUE TO (c) Arterio sclerosis		INTERVAL BETWEEN ONSET AND DEATH Untimely	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 1, 1956, to Sept 26, 1956, that I last saw the deceased alive on Sept 24, 1956, and that death occurred at 12 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Norbert C. Nitsch 9/26/56 PHYSICIAN'S NAME (Type) Norbert C. Nitsch - Rock Hall, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 28, 1956	22c. NAME OF CEMETERY OR CREMATORI St. John's (Catholic)	22d. LOCATION (City, town, or county) (State) Rock Hall, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR DATE Sept 28/56
			24b. REGISTRAR'S SIGNATURE J. Elwood Bringer

MISSOURI STATE DEPARTMENT OF HEALTH - FAMILIAR

CERTIFICATE OF DEATH

BUREAU V. E.

OCT 2 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09400

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) d. STATE Maryland		b. COUNTY Kent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb 8 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Chestertown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent and Queen Ann's		d. STREET ADDRESS Quaker Neck Wharf		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Annie	Middle C.	Last Goodman	4. DATE OF DEATH Sept. 24	Month Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 9, 1873	9. AGE (In years lost birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 0 0 0 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kent County, Maryland	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Woodmender			14. MOTHER'S MAIDEN NAME Sarah Holden		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized circulatory collapse 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Infirmities of advanced years DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH 36 hrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of left femur					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fell		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY 10 Hour o. m. p.m.	Month 9-14	Doy 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Rural-Chestertown, Md.
21. I certify that I attended the deceased from 9-16, 1956, to 9-21, 1956, that I last saw the deceased alive on 9-24, 1956, and that death occurred at 7:30 p.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Chestertown, Maryland DATE SIGNED ACTUAL SIGNATURE A.C. Dick A.C. Dick PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 27, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Chester Cem.	22d. LOCATION (City, town, or county) Chestertown, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR Sept. 26-56	24b. REGISTRAR'S SIGNATURE Clara S. Barnes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARSHAL

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9410 CERTIFICATE OF DEATH

09401

Reg. Dist. No. 203

1. PLACE OF DEATH a. COUNTY <i>Ident</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Ident</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rock Hall</i>	c. LENGTH OF STAY IN lb <i>Life</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rock Hall</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) <i>Mary Elizabeth Journe</i>		First <i>Mary</i>	Middle <i>Elizabeth</i>
4. DATE OF DEATH <i>Sept 19</i>	Month <i>Sept</i>	Day <i>19</i>	Year <i>1956</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>April 16 1887</i>
		DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) <i>29 yrs.</i>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Joseph Miner</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Deelholfer</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>218-20-9707</i>		17. INFORMANT <i>Shirley Journe Rock Hall</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i>			
260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertension Cardiovascular</i>			
DUE TO (c) <i>Deabetes Mellitus</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day <input type="checkbox"/> Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Rock Hall</i>	(County) <i>Md</i>	(State) <i>Md</i>
21. I certify that I attended the deceased from <i>Sept 1</i> , 1956, to <i>Sept 19</i> , 1956, that I last saw the deceased alive on <i>Sept 18</i> , 1956, and that death occurred at <i>8:30 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Rock Hall Md</i>	
ACTUAL SIGNATURE <i>Norbert C. Nitsch</i>	DATE SIGNED		
PHYSICIAN'S NAME (Type) <i>NORBERT C. NITSCH</i>	ROCK HALL MD.		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-21-56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Worley Chapel</i>	22d. LOCATION (City, town, or county) <i>Rock Hall</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar L. Lane Church/kep</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE <i>9/21/56</i>
		24b. REGISTRAR'S SIGNATURE <i>S Elwood Bongen</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WISCONSIN STATE LABORATORY - MILWAUKEE, WI

CERTIFICATE OF DEATH

SEARCHED

INDEXED

SERIALIZED

FILED

BUREAU V. S.

SEP 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9405

CERTIFICATE OF DEATH

09402

Reg. Dist. No.

201

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clesterton	c. LENGTH OF STAY IN 1b 5 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville, Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Gen'l	d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Daniel	First	Middle C.	Last Kelley
4. DATE OF DEATH Sept 15 1956	Month	Day	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 3-1880
9. AGE (In years lost birthday) 76 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY STORE OWNER	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Kelley		14. MOTHER'S MAIDEN NAME Virginia Jewell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 244-32-7434	
17. INFORMANT Mrs Ethel Kelley, Kennedyville, Md Hospital residence		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1		many years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure		many years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/15/56, 1956, to 9/15/56, 1956, that I last saw the deceased alive on 9/15/56, 1956, and that death occurred at 10:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert W. Farr		ADDRESS (Street, city or town, state) Chesterton, Md DATE SIGNED 9/16/56	
PHYSICIAN'S NAME (Type) ROBERT W. FARR			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-18-56	
22c. NAME OF CEMETERY OR CREMATOR Y STILL POND CEMTY		22d. LOCATION (City, town, or county) STILL POND, MD (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy		ADDRESS STILL POND, MD.	
24a. REC'D BY REGISTRAR DATE 8/17/56		24b. REGISTRAR'S SIGNATURE E. Leonard Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH-SAFETY-ENVIRONMENT

CERTIFICATE OF DEATH

2028

BUREAU V. S.
RECEIVED
SEP 19 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9406

CERTIFICATE OF DEATH

09403

Reg. Dist. No. 202

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at Work Peoples Bank High St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles F. Wheatley		First Charles	Middle F.
Last Wheatley		4. DATE OF DEATH 9/6/1956	Month Day Year 19
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/15/1887
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President of Peoples Bank		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Kent Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Wm. A. Wheatley	
14. MOTHER'S MAIDEN NAME Josephine Frazier		15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> [Yes, no, or unknown] [If yes, give war or dates of service] no	
16. SOCIAL SECURITY NO. 212-03-0960		17. INFORMANT Mrs. Avis D. Wheatley	Address Chestertown, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH 10 min.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO Coronary artery disease	
(c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-28 , 19 56 , to 9-6 , 19 56 , that I last saw the deceased alive on 9-3- , 19 56 , and that death occurred at 1:20 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md.		DATE SIGNED 9-6-56	
ACTUAL SIGNATURE A. C. Dick		PHYSICIAN'S NAME (Type) A. C. Dick - Chestertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/9/56	22c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery	22d. LOCATION (City, town, or county) (State) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR Sept. 8-1956
			24b. REGISTRAR'S SIGNATURE Clara S. Barnes

WISCONSIN STATE DEPARTMENT OF HEALTH - SUMMERS 19

CERTIFICATE OF DEATH

NAME

ADDRESS

PHONE

AGE

SEX

RACE

RELIGION

EDUCATION

EMPLOYMENT

DEATH DATE

TIME

CAUSE

DEATH

BUREAU V.

SEP 11 1956

RECEIVED